

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 31637  
8168

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 3 weeks		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 1420 Cole		225	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				d. STREET ADDRESS St. Louis			
3. NAME OF DECEASED (Type or Print) a. (First) Nesbit		b. (Middle) Wilson		c. (Last) Ford		4. DATE OF DEATH (Month) 9 (Day) 25 (Year) '50	
5. SEX Male 2		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1		8. DATE OF BIRTH Dec. 4, 1890	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Port Gibson, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME ?		13b. MOTHER'S MAIDEN NAME Emily		14. NAME OF HUSBAND OR WIFE Lillian Ford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Lillian Ford, 1202 Baker			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia - Hypostatic carcinoma, epidermoid of tongue ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) Undet. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? 141X			
22. I hereby certify that I attended the deceased from 8-22-50 to 9-25-50, 19, that I last saw the deceased alive on 9-25-50, 19, and that death occurred at 7:35 PM, from the causes and on the date stated above.							
23a. SIGNATURE Alvin Thompson				23b. ADDRESS (Degree or title) M. D. 2601 N. Whittier		23c. DATE SIGNED 9-27-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-28-50		24c. NAME OF CEMETERY OR CREMATORY Booker Washington		24d. LOCATION (City, town, or county) (State) E. St. Louis, Illinois	
DATE REC'D BY LOCAL REG. SEP 28 1950		REGISTRAR'S SIGNATURE J. B. Smith		25. FUNERAL DIRECTOR'S SIGNATURE O. V. Nash		ADDRESS 3847 Page	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*C. V. Nash*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2435*

P. O. Address *3847 Payne*

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.